Dental

MONTHLY PROGRESS REPORT ★ SECTION 7

13

HEALTH

RESTRICTED

31 OCTOBER 1945

ARMY SERVICE FORCES ★ WAR DEPARTMENT

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HEALTH

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SUMMARY

RESPIRATORY DISEASE Current statistical trends are highly favorable for respiratory disease, but certain epidemiological signs point to the possibility of an outbreak of influenza this winter. The vaccination of Army personnel against the most common types of influenza is nearing completion. (See pages 2 to 4)

NONEFFECTIVE RATES Except for a slight rise in patients of Z/I origin, noneffective rates overseas and in the Z/I continue their downward trend. The September noneffective population amounted to about 345,000 men, almost 15 percent below the August total. About 175,000, or 50 percent of the aggregate, were evacuees in the Z/I. (See pages 5 to 6)

ADMISSION RATES With few exceptions admission rates also continued to fall in September, total hospital admissions declining from about 315,000 in August to about 285,000 in September. Disease admissions to hospital and quarters during September in the major theaters were generally lower than in August. (See pages 7 to 8)

VENEREAL DISEASE The admission rate for venereal disease mounted very sharply in the Mediterranean Theater during September, reaching 213 per 1,000 men per year, the highest theater rate of the war. In the European Theater there was no further increase during September, and in the Western Pacific there was a marked improvement during August, the latest month reported. (See page 9)

HOSPITALIZATION OVERSEAS On 30 September only 70,000 patients were remaining in fixed and nonfixed hospitals overseas, 35 percent of the 31 May census. Only 257 Army wounded remained in overseas hospitals. By 10 November, fixed hospital units with a T/O capacity of 101,700 beds had been returned to the U. S. from the European area and units with an aggregate capacity of 83,600 had been inactivated here. (See pages 10 to 12)

EVACUATION FROM OVERSEAS Transportation sources report 17,400 Army patients debarked in the Z/I during October, almost 1,000 below the September count. Patients returned from the Pacific numbered about 11,000. The volume of air evacuation fell to 4,300, only one-fourth the aggregate, while the lift by water increased slightly. (See page 13)

HOSPITALIZATION IN THE Z/I During October steps were taken to implement the planned contraction of the general hospital system to accord with reduced patient loads. Nineteen general hospitals scheduled for closure 31 December ceased to receive new patients on 10 October. Specialist personnel qualified to care for the residue of long-term patients is becoming scarce and further economies may be necessary. (See pages 14 to 16)

MORTALITY DURING THE WAR About 266,500 Army personnel were killed or died during the war period, about 75 percent from battle causes. The proportions dying among all hospital and quarters admissions were 0.09 percent for disease and 2.5 percent for those accidentally injured, while 4.4 percent of all the wounded admitted to hospital died. Comparisons are made with previous wars. (See pages 17 to 19)

DISEASE AND INJURY

RESPIRATORY DISEASE

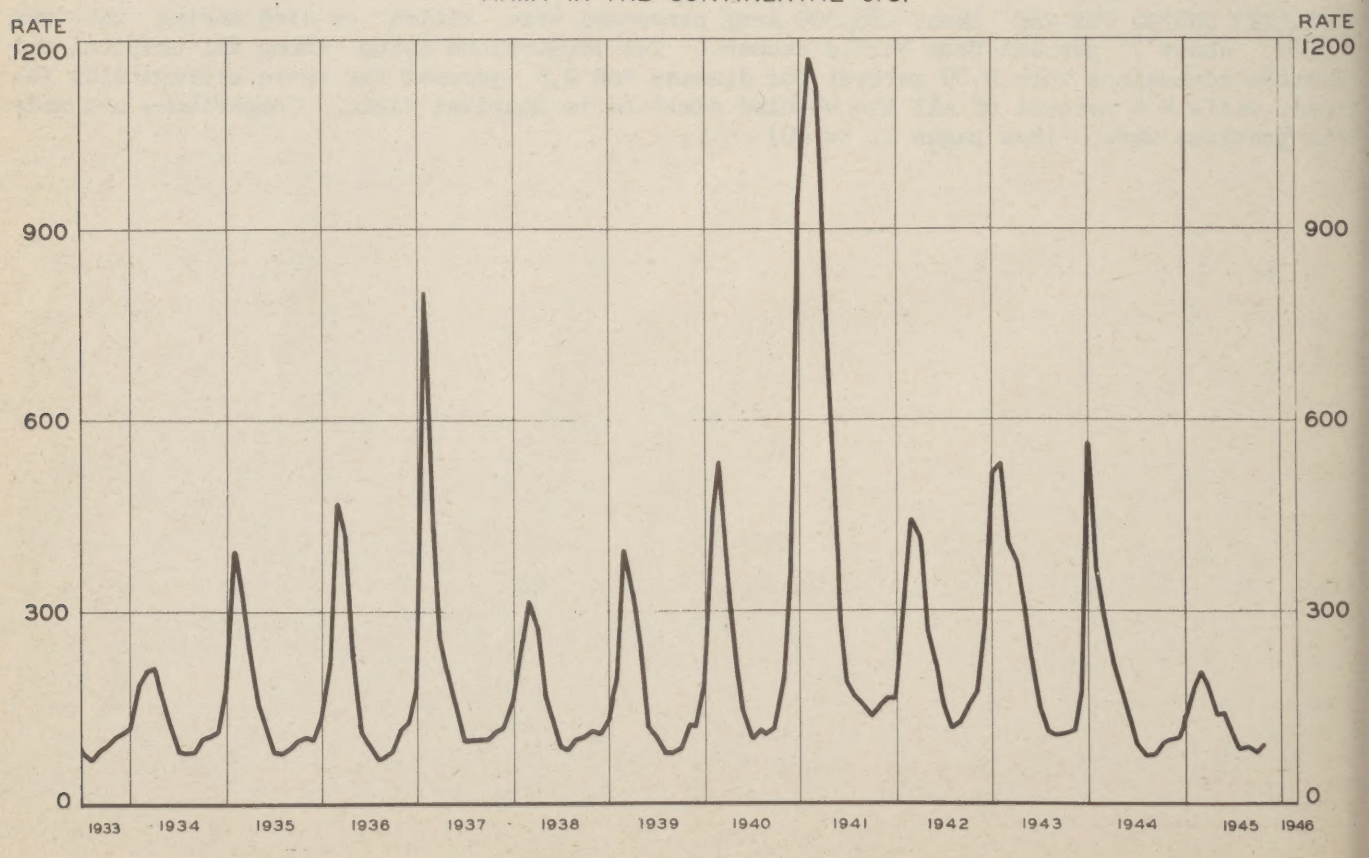
Each year a large and unpredictable toll of the effective manpower of the Army is taken by the respiratory diseases, which comprise chiefly the common cold, the influenzas and the pneumonias, and include both bacterial and virus infections. Particular interest attaches to the coming respiratory season in the northern latitudes because the past season was the most favorable in years, because a number of minor localized outbreaks of influenza type B have already occurred this year, and because the Army is now completing the first mass influenza vaccination in history. Apart from the normal seasonal variation, the tremendous changes in the amplitude of the yearly swings in the incidence of respiratory disease result largely from the occurrence or nonoccurrence of influenza epidemics. Effective control of influenzas would thus ensure a large reduction in the waste of manpower caused by the respiratory diseases.

The first chart below presents the most recent Z/I admission experience in conjunction with similar rates for the previous 12 years. The major epidemic years contrast sharply with the other years, dwarfing even the 1943 epidemic of influenza type A. Most remarkable, however, is the past season, which was so much lower than any year in the past decade. Since World War I only the 1929-1930 and the 1933-1934 seasons closely approximate the 1944-1945 winter period in terms of incidence, and neither was so favorable. Predictions about the coming season are at best hazardous. Clearly the trend is again most favorable, the October rate of 88 being, in fact, the lowest October rate since 1915. Absence of an early fall upswing is not, of course, indicative that the entire winter season will be favorable, as may be seen from the experience in 1943 when an epidemic began in November after extremely moderate increases in September and October.

It is not characteristic of epidemics to manifest themselves simultaneously in all places; a few localities take the lead and a definite geographical movement can usually be traced. For this reason there is some hope of detecting advance signs of epidemic changes by following the movement of the highest rates for each report period. The accompanying chart gives the weekly rates which were exceeded by ten percent of the stations of 5,000 or more strength in 1943, 1944, and 1945. Through the fourth week of October even this sensitive index had failed to register any suggestion of a radical change. Similarly, certain of the service commands, notably the Sixth and Seventh, are prone to have especially high rates

RESPIRATORY DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR

ARMY IN THE CONTINENTAL U.S.



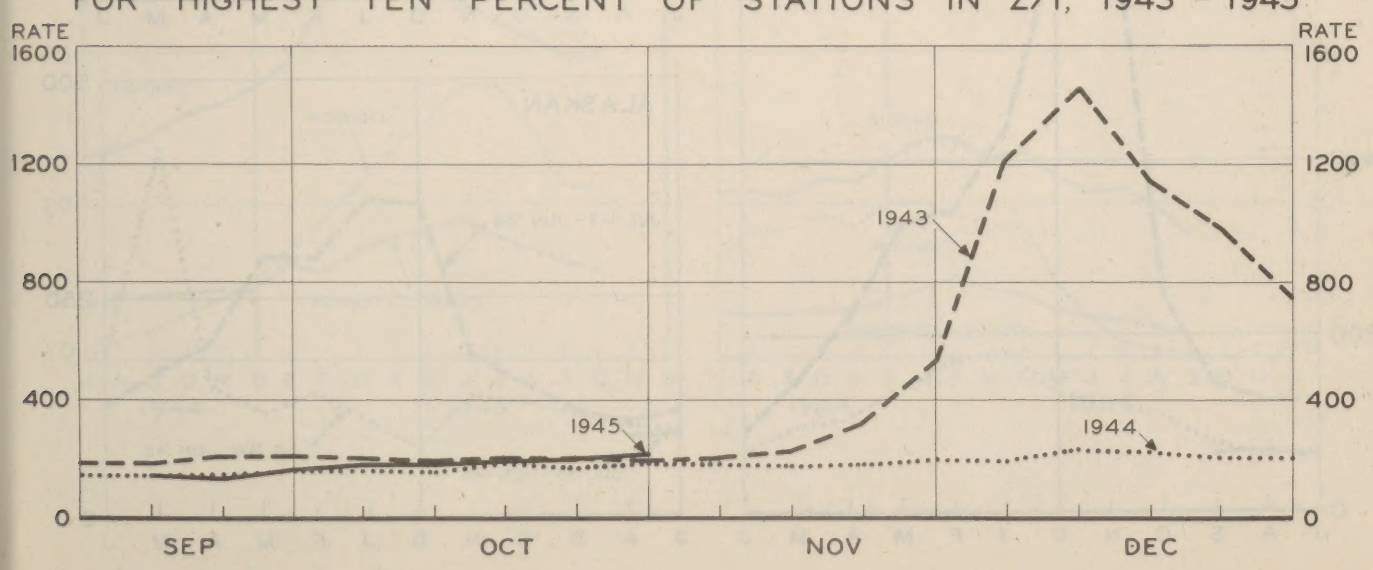
RESPIRATORY DISEASE (Continued)

during the epidemic season and will bear watching. Thus far this year, however, in none of the service commands has the admission rate risen to a high level either precipitately or more slowly, the highest rate being 125 for the Eighth Service Command for the week ending 26 October. The Military District of Washington has had uniformly higher rates than any of the service commands.

Despite the favorable statistical trend through October, certain qualitative information points to the need for a cautious outlook. First is the confirmed presence of influenza virus B in outbreaks at several posts late in the spring of the year and at others early this fall; second is the fact that sharp outbreaks of influenza B are known to have occurred among troops in Alaska, Hawaii, and Panama in the late spring and early summer of this year; and third is the theoretical expectation of an epidemic of either influenza A or B this year in the light of previous epidemiological experience. It was largely for these reasons that the decision was made to immunize the entire Army with the vaccine now available against influenza types A and B. Clinical experiments during the 1941-1942 season and also in the fall of 1943 provide convincing evidence of at least the temporary effectiveness of the vaccine against the viruses present then. As the type of virus responsible for the 1918 epidemic is not known, however, no guarantee can be given that a vaccine composed of types A and B will protect against the kind of influenza which was pandemic at that time. However, the A and B viruses have been the main causes of influenza in recent years. Both Army laboratories and those associated with the Army Epidemiological Board maintain a constant alert for signs of influenza in any suspicious outbreak of respiratory disease in the Z/I. The presence of influenza virus B has been identified at four stations in the Z/I since August. Particularly close watch is being kept on one station with a rate about four times the national average where laboratory tests have demonstrated the presence of influenza virus B in several cases. Action has also been taken to increase the minimum space allowance in barracks to the pre-war standard of 60 square feet per man wherever practicable. During the war this was generally lowered to 40 square feet.

Overseas as well as in the Z/I the 1944-1945 respiratory season in northern latitudes was quite favorable except for the late spring or early summer outbreaks of influenza B in Alaska, Panama, and the Middle Pacific. The most recent rates for each major command appear in the accompanying panels against the background of previous seasons. For Alaska, the European Theater, and the Mediterranean Theater, where the seasonal variation is greatest and the peak incidence occurs from December through February, the season is shown as extending from July of one year to June of the next. The May epidemic in Alaska, believed to have been caused by influenza virus B, was clinically mild but widespread throughout the area. The May rate is the highest of the war period for Alaska. A similar but less widespread epidemic occurred in the Panama Canal Department in June and also sent the admission rate to the highest point of the war in this command. It was concurrent with a more extensive outbreak in the civilian population. Laboratory studies have identified the causative agent as influenza virus B. At about the same time a similar epidemic occurred at Jamaica, B.W.I. The outbreak of influenza on Oahu was much less extensive in the military population. May ci-

RESPIRATORY DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR
FOR HIGHEST TEN PERCENT OF STATIONS IN Z/I, 1943 - 1945

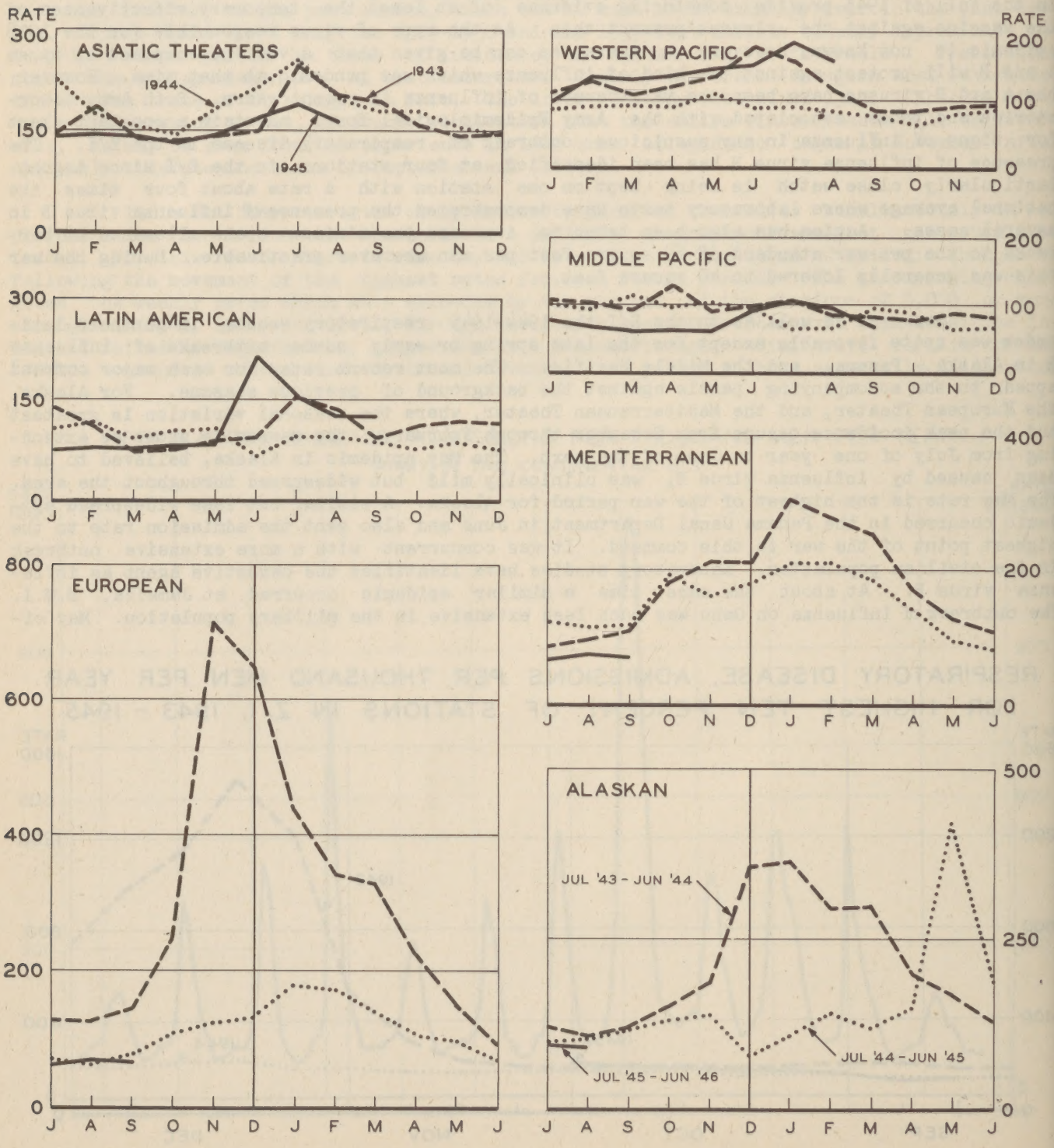


RESPIRATORY DISEASE (Continued)

vilian cases were reported in June, and admissions for the military also increased to a point well above the level of previous months without, however, being remarkably numerous. Influenza virus B was identified in cases on Oahu and also on Tarawa, where 86 percent of the small garrison was affected within ten days.

In the European Theater the peak admission rate during the past winter was but one-fourth the usual maximum, and the most recent rates are well below those reported for similar months in 1942 and 1943. The variation in the Mediterranean and Africa-Middle East Theaters has not been so marked, but current rates there also are unusually favorable. In the Southwest Pacific recent rates have been higher than usual (see HEALTH for September) but there was a substantial decline in August for the first time since the Philippine Campaign began.

RESPIRATORY DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR
OVERSEAS THEATERS 1943 - 1945



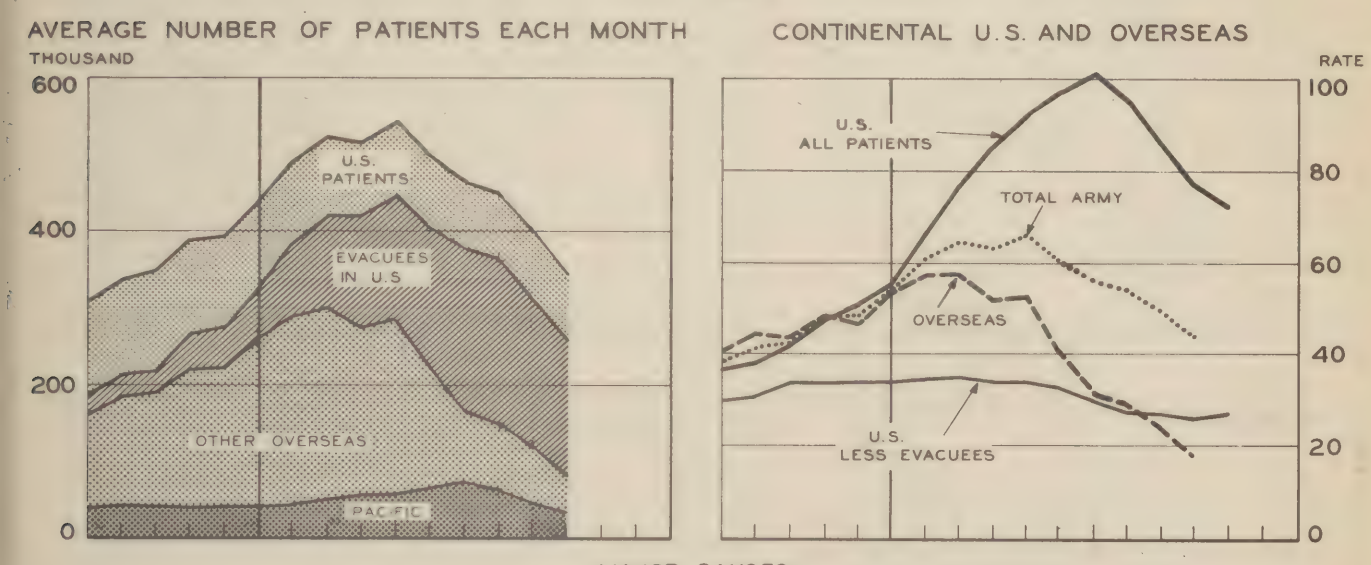
NONEFFECTIVES IN HOSPITAL AND QUARTERS

For the Army as a whole the noneffective population continued to lessen both absolutely and relatively during September. The average number of men noneffective was about 345,000, or almost 15 percent below the August count, while the rate declined from 50 to 44 per thousand strength. Evacuees in the Z/I continue to constitute the greatest part of the noneffective population, accounting for about 50 percent of the entire Army load during September. In October the size of this segment was further reduced and noneffectives of Z/I origin increased slightly relative to strength. The greatest change in the Z/I rate is occurring in the component for wounded, which was down to 22 per thousand strength in October. Neuropsychiatric patients declined from 30,000 to 22,000, the rate for October being seven per thousand strength.

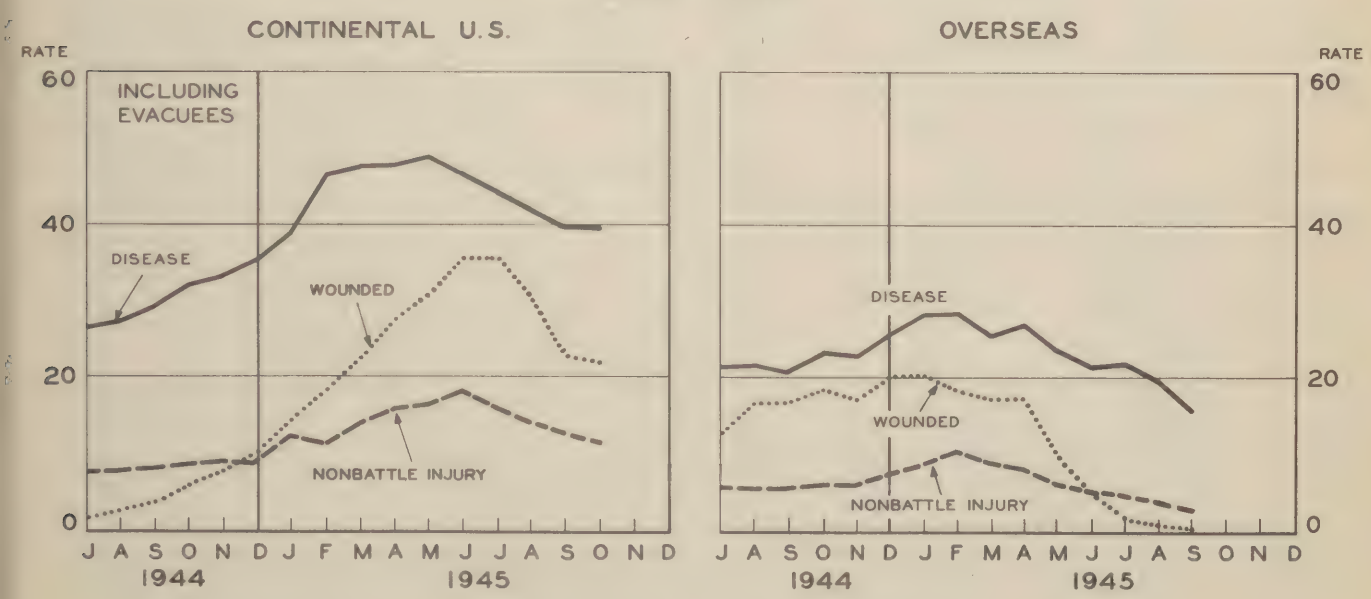
Even more rapid than the decline in Z/I rates is that which is taking place overseas. In September the average noneffective rate for all forces overseas was down to 18 per 1,000 strength, the lowest point in the war record and well below the corrected Z/I rate (excluding evacuees) of 26. All three components of the overseas rate fell during September, and that for wounded became entirely negligible.

AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES



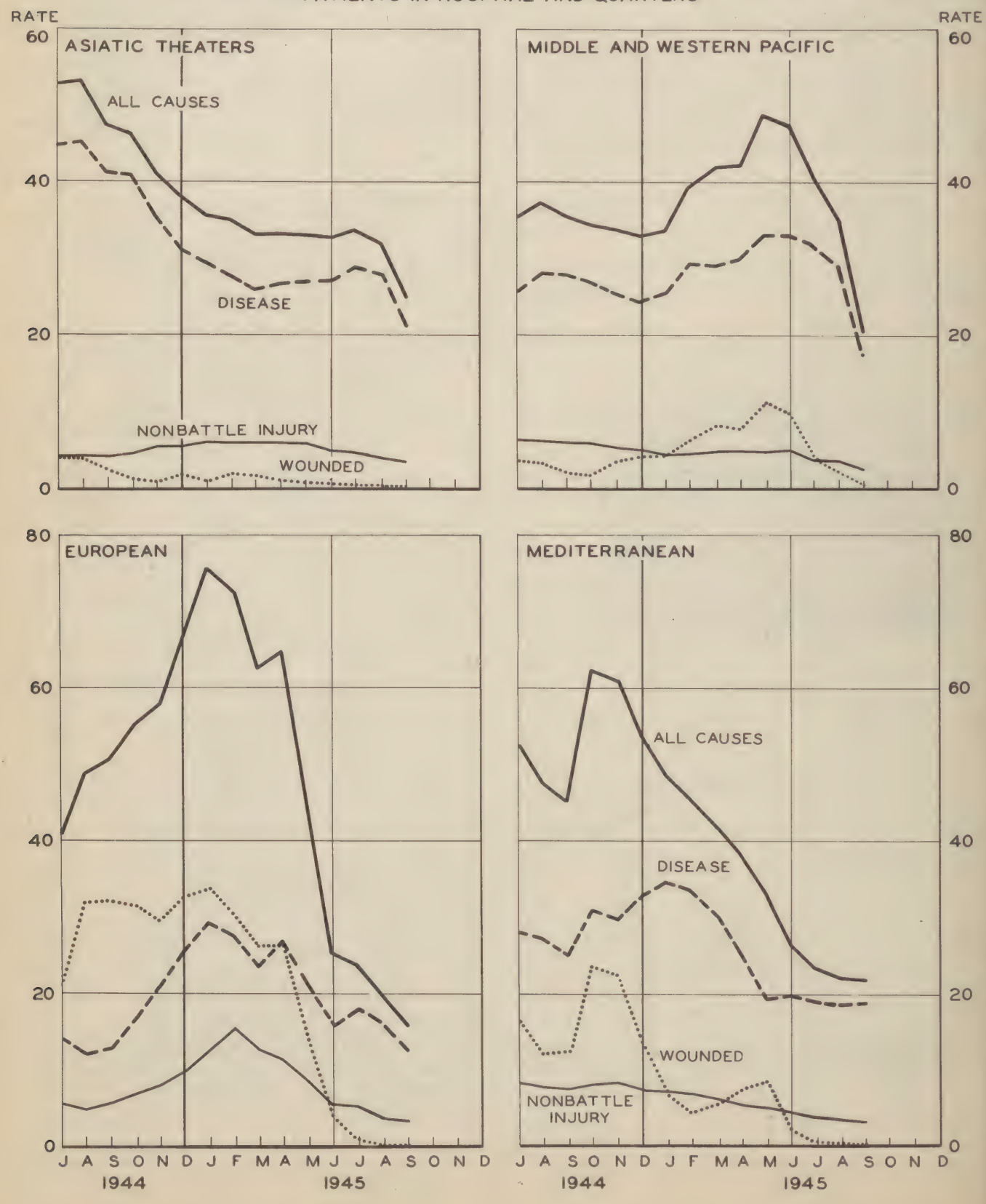
MAJOR CAUSES



NONEFFECTIVES IN HOSPITAL AND QUARTERS, U. S. AND OVERSEAS (Continued)

Almost without exception overseas noneffective rates for disease and injury are lower than at any time during the war period. Only the Mediterranean Theater reported an increase in any major portion of the noneffective rate during September, and it was slight. The sharp decrease in the rates for the Middle and Western Pacific and the Asiatic theaters during September is noteworthy.

AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH
PATIENTS IN HOSPITAL AND QUARTERS



DISEASE AND INJURY

TREND OF HOSPITAL ADMISSIONS IN THE U. S. AND OVERSEAS

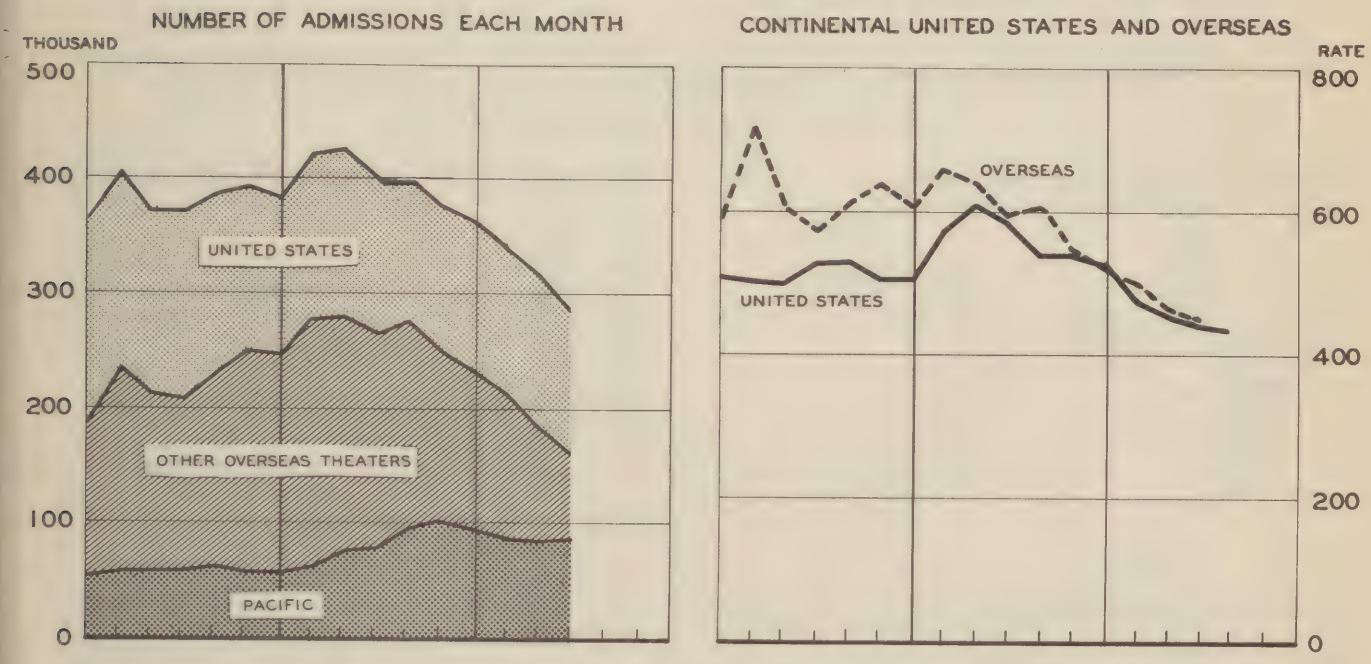
Preliminary radio reports from the overseas theaters reveal a further decline in the hospital admission rate overseas during September, the rate of 445 per thousand men per year being lower than any since January 1942. Similarly, the rate for troops in the United States dropped to 438 in September and to 434 in October. During September 287,000 Army patients were admitted to hospital directly or transferred to hospitals from other medical installations, about nine percent fewer than in August. In the United States the number of admissions also declined in spite of the return of large numbers of troops from overseas, about 124,000 soldiers entering hospitals during the month in contrast to 133,000 in August.

The accompanying panels present the most recent rates and numbers of admissions against the background of the trends since June 1944.

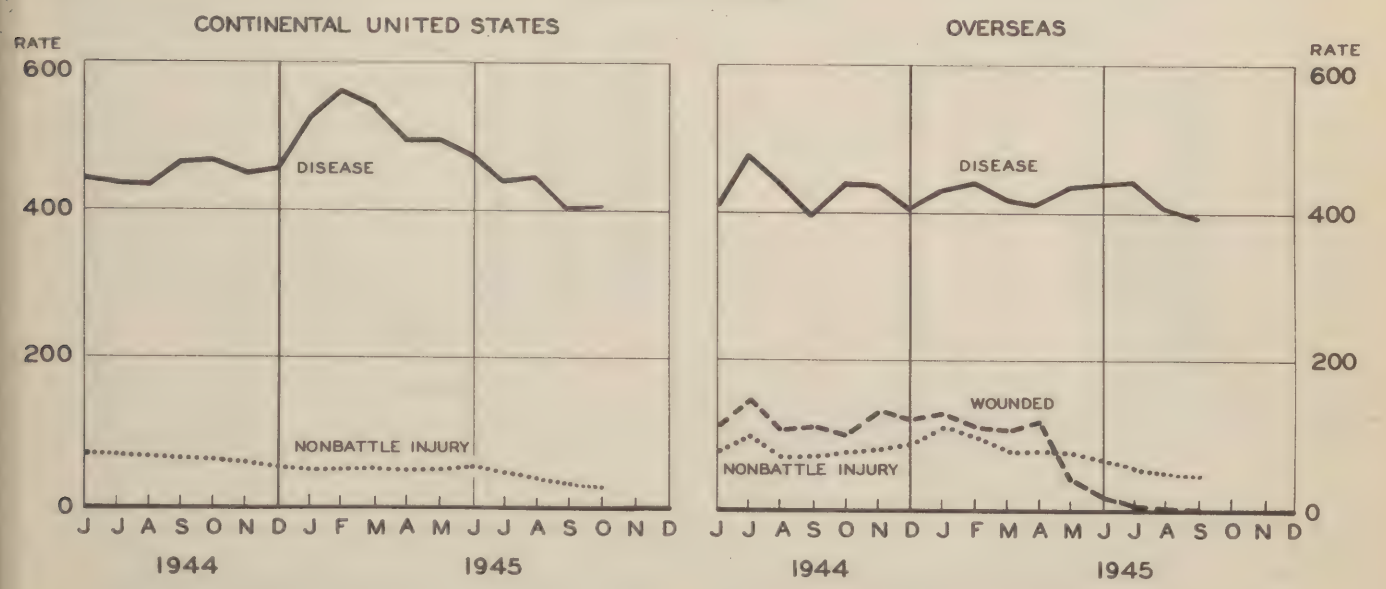
DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS

RATES PER THOUSAND MEN PER YEAR

ALL CAUSES



MAJOR CAUSES



DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS IN OVERSEAS THEATERS

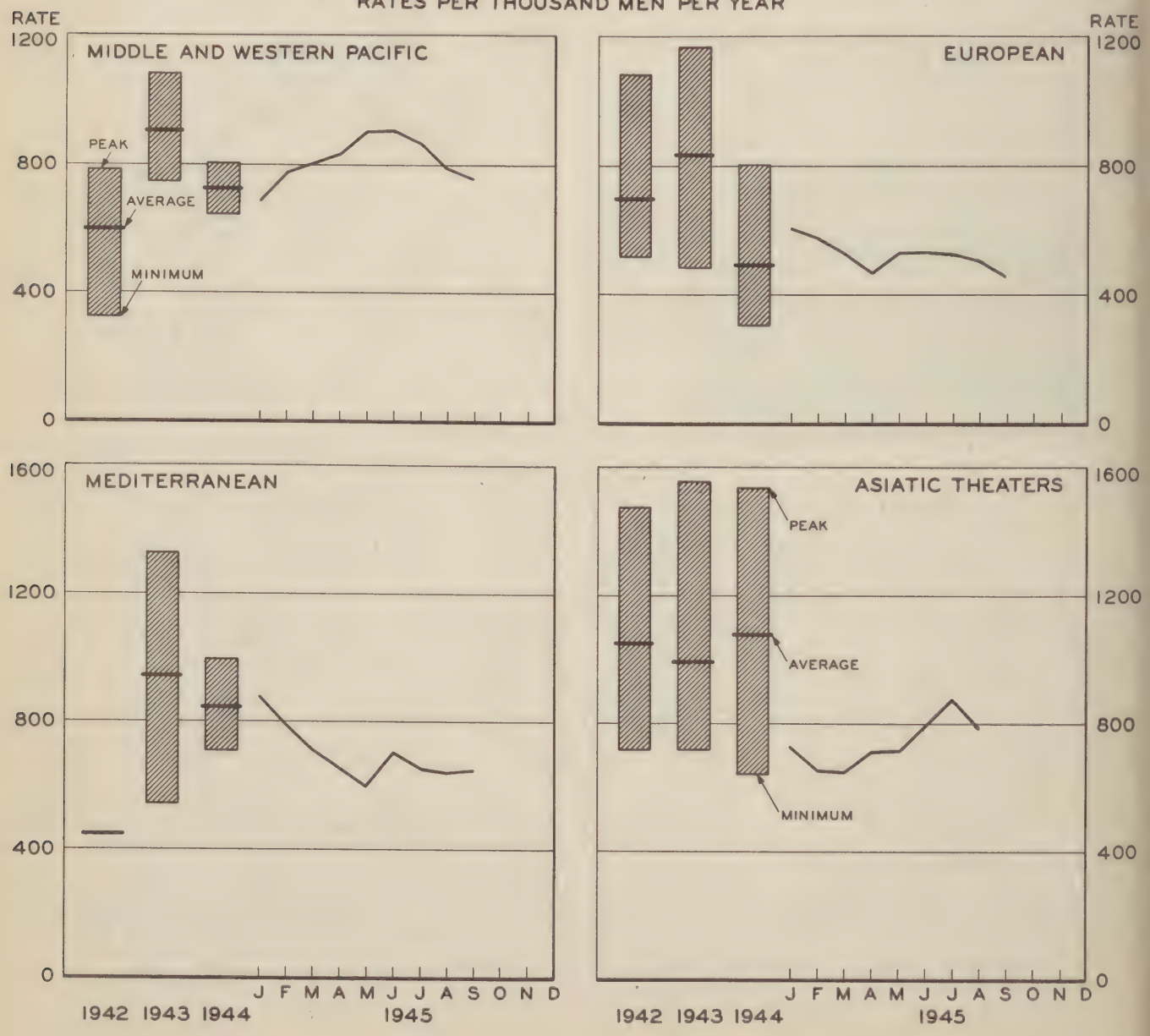
Disease admissions to hospital and quarters in the four major areas of troop concentration overseas appear in rate form in the chart below. The bars in each panel give the admission rates for the months of highest and lowest incidence in each year prior to 1945 and the line across each bar gives the average rate for that year.

In each of the areas except the Mediterranean the most recent rate is below that of the previous month. In the Mediterranean the downward trend of July and August was reversed when the September rate advanced slightly to 649 admissions per thousand men per year. This increase resulted entirely from the higher venereal disease rate which constitutes 55 percent of the rate for all communicable diseases and 33 percent of the rate for all diseases during the month. The incidence of noncommunicable disease decreased by about ten percent between May and September.

In the Middle Pacific, which is not shown separately below, the disease admission rate declined for the first time since March, prior to the beginning of the Okinawa Campaign, reaching 466 in August and 465 in September. The August rate of 891 for the Western Pacific represents the third successive monthly decline.

DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

RATES PER THOUSAND MEN PER YEAR

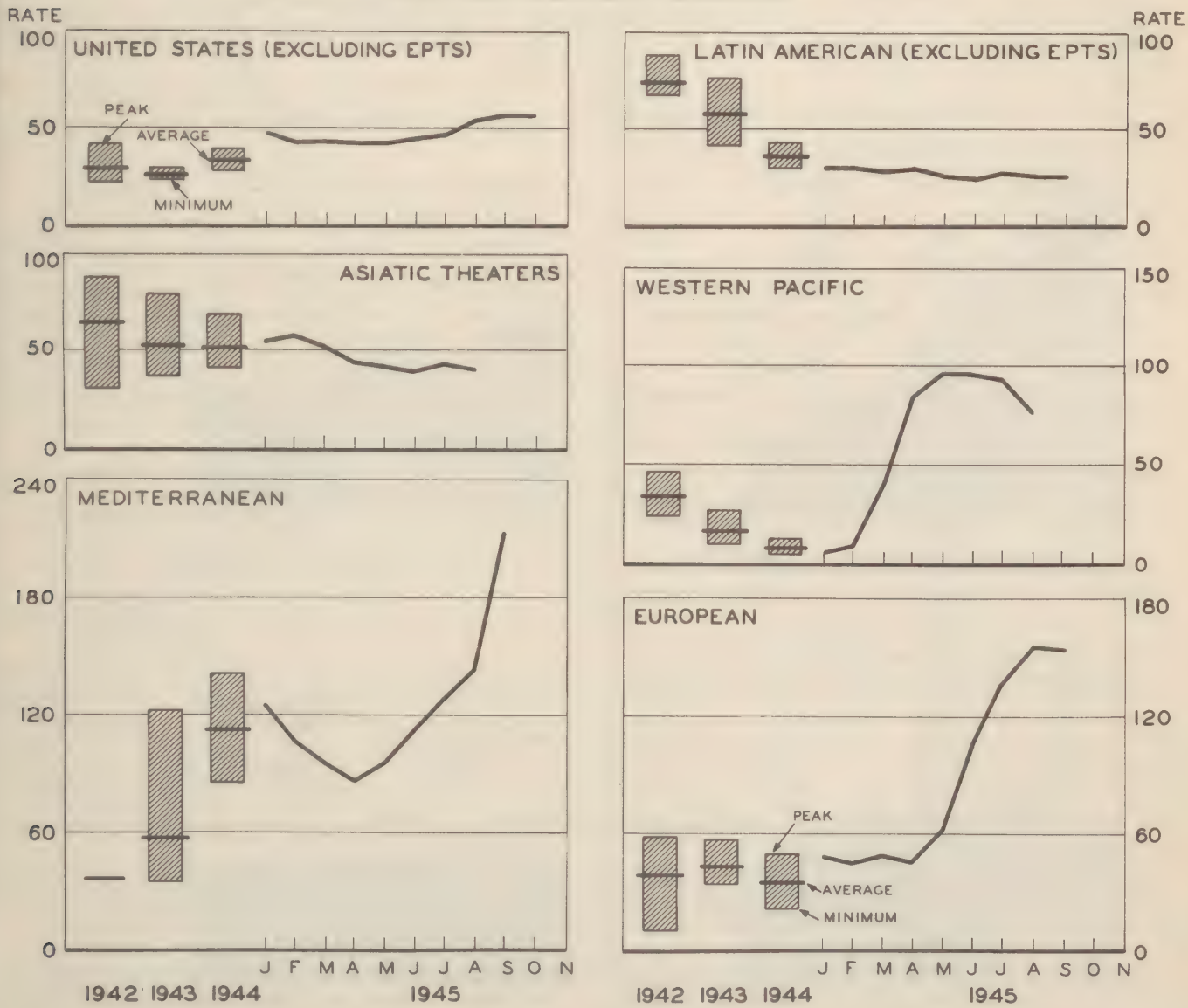


INCIDENCE OF VENEREAL DISEASE

The most recent reports from overseas theaters reveal three highly significant facts about the incidence of venereal disease. In the Mediterranean Theater the admission rate changed the direction of its rise and shot up to 213 in September. Examination of the separate rates for white and Negro troops shows that the rate for whites advanced from 102 in August to 149 in September, while that for Negroes rose from 357 to 484 per thousand men per year. The increase in the total theater rate cannot be explained by any substantial change in the ratio of Negro to white troops. The second fact of importance is the evidence that the rate in the European Theater may have reached at least a temporary maximum, for the September rate of 154 is actually a point below that of 155 for August. The third fact is the sharp decline in incidence in the Western Pacific. The August rate of 77 is almost 20 percent below the July rate of 94.

In the Z/I the high September rate of 57 was unchanged in October, but there was considerable weekly fluctuation. For the week ending 26 October, for example, a rate of 66 was reported.

VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR
U.S. AND OVERSEAS COMMANDS



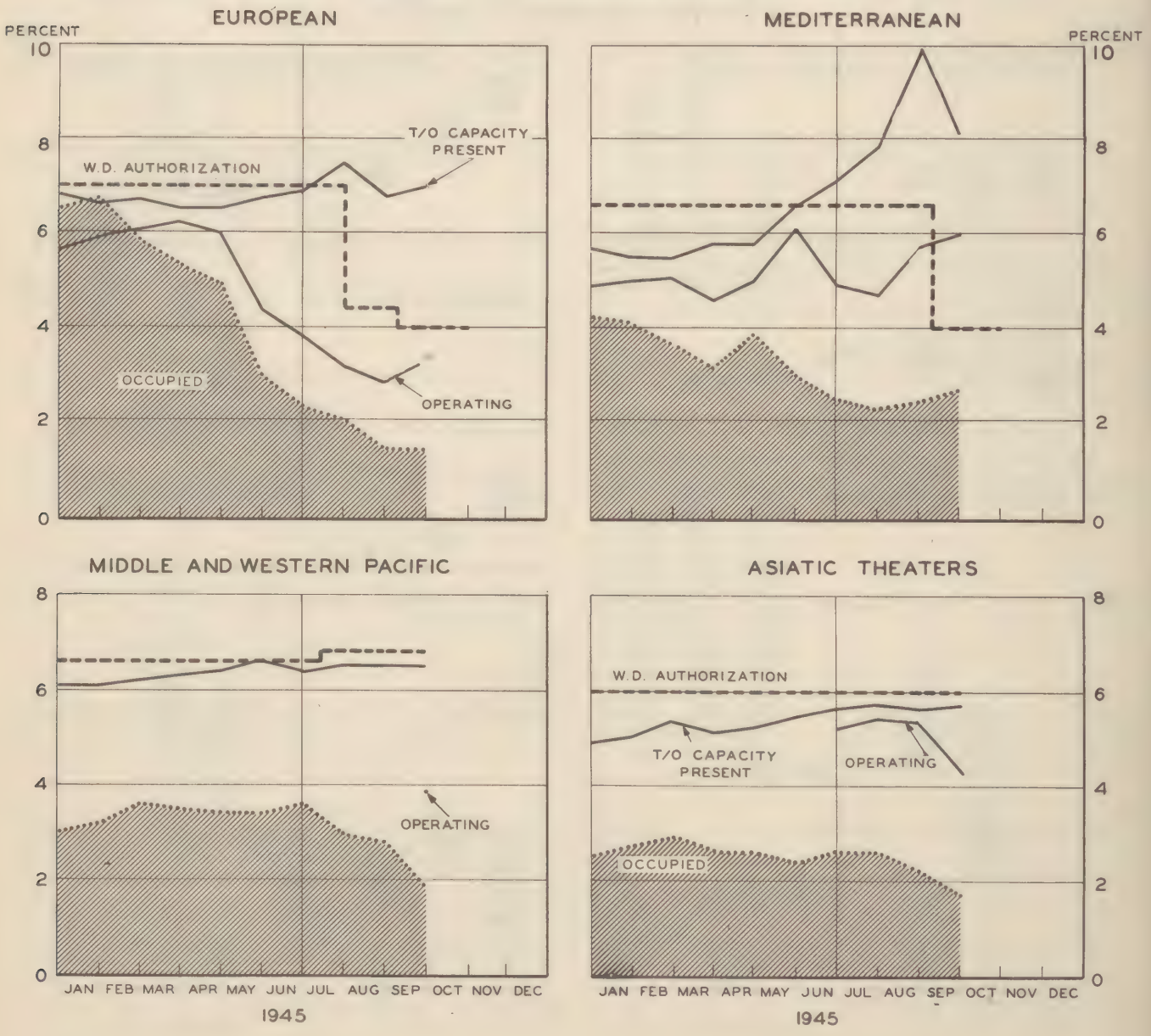
HOSPITALIZATION OVERSEAS

During September there was a further sharp reduction in the census of patients remaining in Army Hospitals overseas, the count of 70,000 being but 71 percent of the 31 August census and 35 percent of that for 31 May. Fixed bed capacity declined from 288,000 to 257,000 the same proportionate reduction which occurred in the total overseas strength. However, fixed hospitals in operation had only 143,000 beds, or 56 percent of the T/O capacity of all fixed units overseas. The T/O capacity of units present in a theater no longer constitutes a meaningful index to the medical personnel present because many units are entirely out of operation and have only skeleton staffs remaining. Very little importance attaches, therefore, to the large apparent excess in T/O capacity reported by the European and Mediterranean Theaters. In these theaters the percentage authorizations have been reduced to an appropriate level of 4.0 percent, but the authorizations of 6.0 for the Middle Pacific and 7.0 for the Western Pacific have not yet been replaced by the 4.8 percent believed to be more suitable for the needs of an Army of occupation in that area. The fixed operating capacity in both areas is, however, in line with current requirements: 3.8 percent in the Pacific and 3.2 percent in the European Theater.

In all theaters fixed bed occupancy is extremely low, as may be seen from reference

FIXED HOSPITALIZATION IN OVERSEAS THEATERS

BEDS AS PERCENT OF STRENGTH



HOSPITALIZATION OVERSEAS (Continued)

to the accompanying charts for fixed beds. The fixed hospital population declined from 87,000 to 65,000 during September according to telegraphic reports to The Surgeon General. Especially striking were the reductions in the Pacific and in the Asiatic theaters. Of the 65,000 fixed beds occupied, 2,200 were filled by prisoners of war, 900 of whom were in the Pacific. The PW population in Army hospitals is rapidly approaching insignificance. An additional 5,300 prisoners of war were being cared for in special hospitals for non-Army patients, mostly in the European Theater. There were 257 wounded Army patients remaining in overseas hospitals at the end of September, almost all in the Pacific.

The patient census of mobile hospitals declined by more than 50 percent during September to reach 5,800, about 60 percent of whom were in the European Theater. This census represents eight percent of the mobile T/O capacity present and 24 percent of the operating capacity at the end of September. The table on the following page gives the details for 30 September.

The chart on page 12 shows the progress made in liquidating the fixed hospitalization capacity present in the European area on 31 May 1945. Of 247,000 T/O fixed bed units present at that time, only 146,000 remained on 10 November, and of these 9,600 had been or were scheduled to be inactivated abroad and 39,000 were earmarked for inactivation upon arrival at U. S. ports, at dates yet unspecified. Of the approximately 108,000 T/O fixed beds

FIXED BEDS AVAILABLE AND OCCUPIED
Number of Beds, 30 September 1945

Theater	W. D. Authorization	T/O Present		Operating c/		Occupied c/
		Number b/	Percent of Authorization	Number	Percent of T/O Present	
ALL THEATERS	206,505	257,275	125	142,821	56	64,577
American a/	3,808	4,200	110	4,815	115	1,456
European	67,745	118,100	174	54,150	46	23,526
Mediterranean	6,561	13,350	203	9,900	74	4,231
Pacific	110,028	104,800	95	60,746 d/	58 d/	30,496 d/
Asiatic	16,115	15,425	96	11,625	75	4,399
Africa-Middle East	2,248	1,400	62	1,585	113	469

Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) e/	W. D. Authorization (Percent)	Bed Capacity		Beds Occupied as		
			T/O Present b/	Operating	Percent of Strength	Percent of T/O Present	Percent of Operating
ALL THEATERS	3,908	5.3	6.6	3.7	1.7	25	45
American a/	127	3.0	3.3	3.8	1.1	35	30
European	1,694	4.0	7.0	3.2	1.4	20	43
Mediterranean	164	4.0	8.1	6.0	2.6	32	43
Pacific	1,617	6.8	6.5	3.8 d/	1.9 d/	29 d/	50 d/
Asiatic	269	6.0	5.7	4.3	1.6	29	38
Africa-Middle East	37	6.0	3.7	4.2	1.3	34	30

a/ Includes Alaskan Department and excludes Eastern and Central Canada
b/ T.L.O.S. dated 1 October 1945 except for Mediterranean, where 8,800 T.L.O.S. count was rejected in favor of telegraphic report on ground that T.L.O.S. reflected deactivation authorizations not yet acted upon.
c/ Reported by theaters telegraphically for 28 September 1945.
d/ Estimated from incomplete theater reports.
e/ Geographic strength by theater, excluding personnel enroute to or from overseas theaters. Strength for Asiatic theaters includes allowance of 70,000 Chinese in India-Burma, the last reported count. The present strength is unknown.

HOSPITALIZATION OVERSEAS (Continued)

present in the Pacific and Asiatic theaters on 31 May, and augmented by subsequent shipments, only 1,000 had been returned to the Z/I by 10 November, but 11,000 had been or were to be inactivated abroad and another 16,000 were scheduled for inactivation upon arrival at U. S. ports at unspecified dates.

NONFIXED BEDS AVAILABLE AND OCCUPIED
Overseas Theaters, 30 September 1945

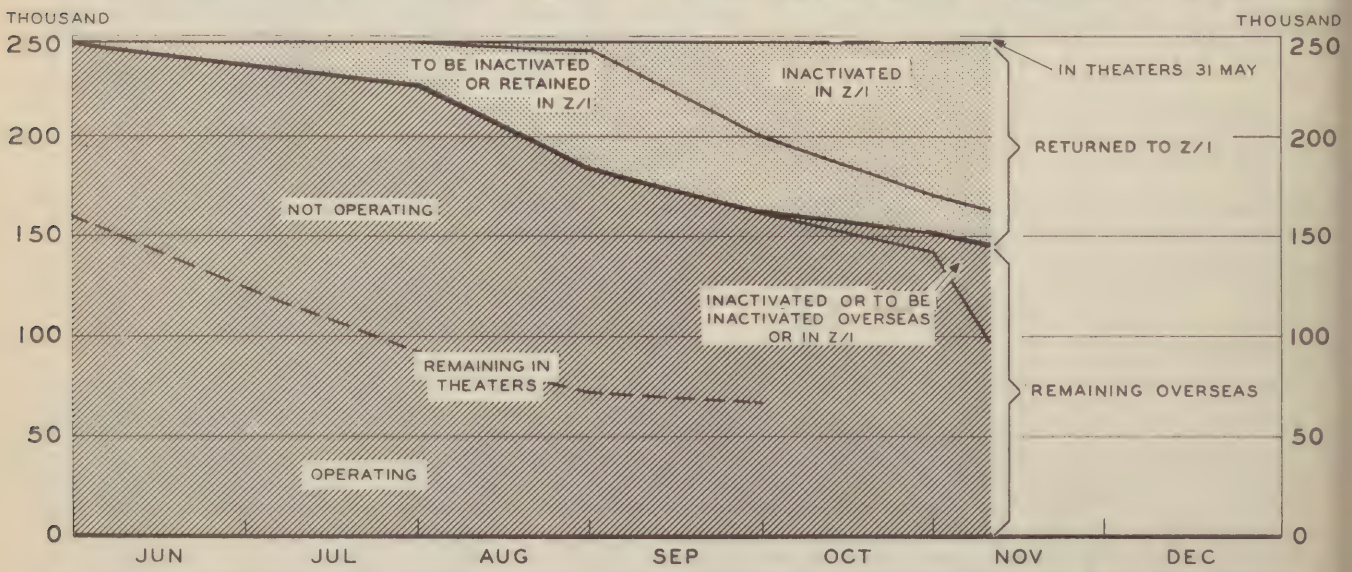
Theater	T/O Present		Operating		Total Occupied			
	Number a/	Percent of Strength	Number b/	Percent of T/O Present	Number b/	Percent of T/O Present	Percent of Operating	Percent of Strength
ALL THEATERS	69,675	1.8	24,620	35	5,817	8.3	23.6	0.1
European	49,175	2.9	16,240	33	3,507	7.1	21.6	0.2
Mediterranean	750	0.5	750	100	39	5.2	5.2	0.0
Pacific	14,775	0.9	6,880c/	47c/	1,891c/	12.8c/	27.5c/	0.1c/
Asiatic	4,975	1.9	750	15	380	7.6	50.7	0.1

PATIENTS REMAINING IN NUMBERED FIXED AND NONFIXED HOSPITALS b/
Overseas Theaters, 30 September 1945

Theater	Total Patients Remaining	Percent Remaining in		Percent Who Were		
		Fixed Units	Nonfixed Units	Army Patients	PW Patients	Other Patients
ALL THEATERS	70,394	92	8	86	4	10
American	1,456	100	0	90	0	10
European	27,033	87	13	91	2	7
Mediterranean	4,270	99	1	79	18	3
Pacific c/	32,387	94	6	83	4	13
Asiatic	4,779	92	8	84	0	16
Africa-Middle East	469	100	0	83	0	17

a/ T.L.O.S. dated 1 October 1945. b/ Reported by theaters telegraphically for 28 September.
c/ Estimated from incomplete theater reports.

DISPOSITION OF FIXED BEDS* IN THE EUROPEAN THEATERS, 1945



* Including field hospitals, some of which are mobile. Units in European, Mediterranean, and Africa Middle East Theaters and Persian Gulf Command are included.

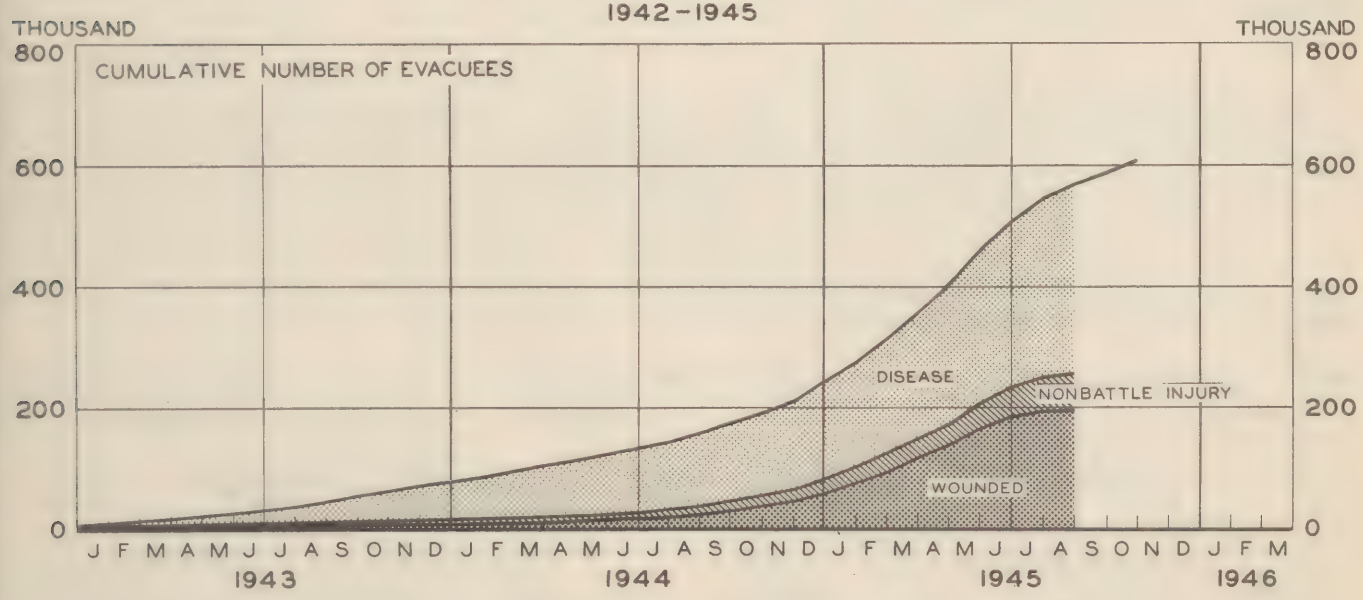
TREND OF EVACUATION FROM OVERSEAS

Army patients debarked in the Z/I from overseas numbered only 17,400 in October, the lowest total since October 1944 and 1,000 below the September count. Unless they were returned as Army patients RAMP's are excluded. The decline occurred entirely in the volume of air evacuation, the total of 4,300 brought back by air being the smallest since December 1944, and only one-fourth of the aggregate water and air figure in contrast to the usual fraction of one-third. The lift from the Pacific was sustained at 11,000, but the greatly reduced hospital population and the decision to resume a 120-day evacuation policy on 1 December mean that this level cannot long be maintained. Less than 4,000 Army patients arrived from the European Theater. Taken in relation to strength the lift from the Asiatic theaters continued high for the second successive month. The top two panels below give the recent evacuation experience in rate form for the Pacific and for all foreign theaters, air and water evacuation being shown separately.

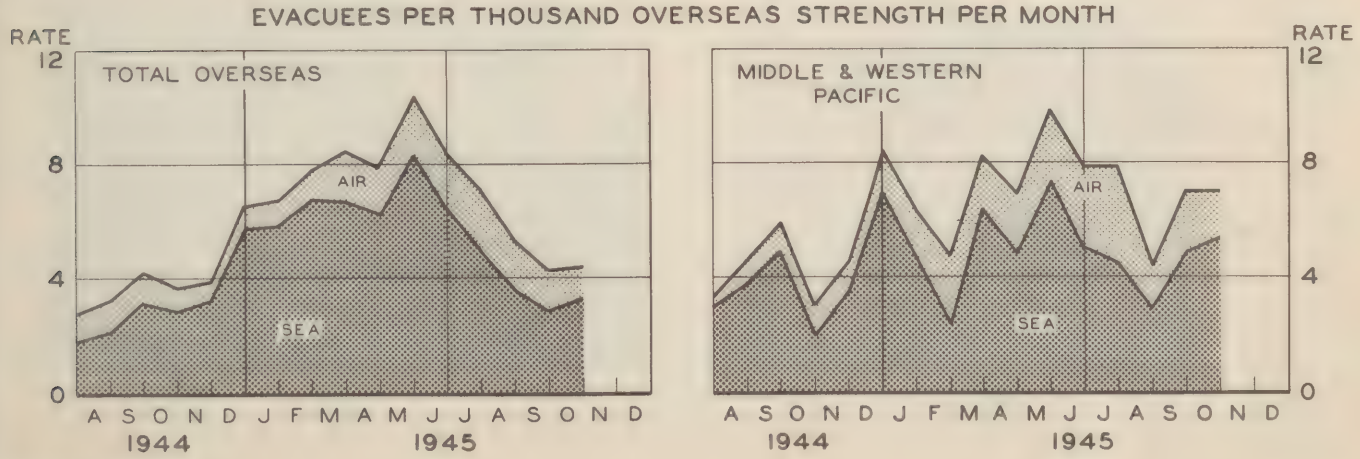
The chart at the bottom of the page gives a cumulative picture of Army patients evacuated from overseas by broad cause groups. Through August 1945 the data are based on individual medical records which provide a count approximately two per cent larger than do the transportation records used for more current reporting. From 1 January 1942 through 31 October 1945 604,000 Army patients were debarked in the Z/I. By the end of August the percentages for each cause group were 34 for wounded, 11 percent for injured patients, and 55 percent for disease patients. Since June the proportions have been shifting slightly in favor of the nonbattle fractions as the number of wounded remaining in hospital overseas has approached negligible size. Those for each month are now, of course, radically different. For example, for August they are 9 percent for wounded, 17 percent for injured, and 74 percent for disease patients.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS

1942-1945



EVACUEES PER THOUSAND OVERSEAS STRENGTH PER MONTH



HOSPITALIZATION IN THE ZONE OF INTERIOR

In October, active implementation began of the plan for contracting the general hospital system. What has taken five years to develop will be liquidated in less than a year, leaving approximately ten general hospitals to meet the needs of the Army during the interim period. The remaining 55 general hospitals and most of the convalescent hospitals will have been declared surplus or reduced to station hospital status by the end of 1946, with their personnel returned to civilian life.

Large-scale contraction of the system has been made possible by the continuous decline in the number of patients evacuated from overseas, which fell below 20,000 in October for the second straight month. Since dispositions of overseas patients have approximated 40,000 monthly since July, a sizable decrease in the number of overseas Army patients in the general hospital system -- from a peak of 201,000 in July to 130,000 in October -- was bound to result. This large decrease has, of course, not been offset by the upward trend in the numbers of zone of interior Army patients in the system, which have increased from 29,000 in July to 35,000 in October.

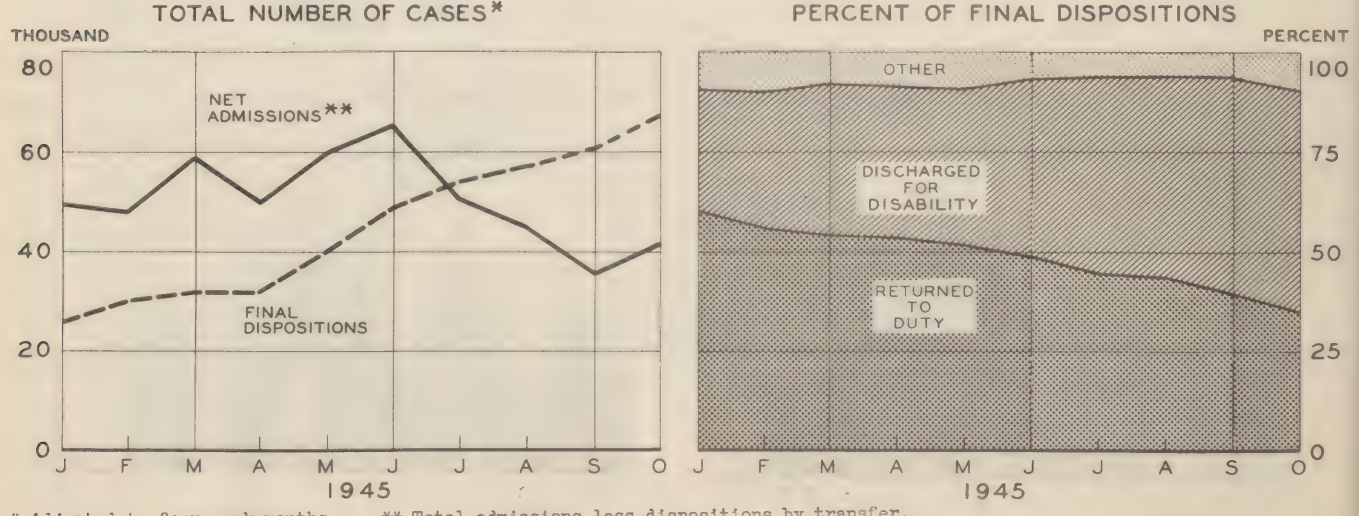
As patient load declines, it is noteworthy that changes in its composition by diagnostic specialty group do not keep pace with changes in the composition of the monthly patient evacuee inflow from overseas. Long-term patients, like plastic or neurosurgical, remain in the hospitals in substantial numbers, although their numbers evacuated from overseas have been sharply reduced.

The plan for contraction of the general hospital system aimed at maximum economies in specialist personnel by closure of entire units; at improvement in the geographic distribution of beds relative to the homes of the patients by closing units in the more sparsely populated sections of the country; and at retaining hospitals during the initial phases of closure which are designated as specialty centers for long-time patients, such as plastic or amputee. The last consideration is weighty because of the importance of an uninterrupted doctor-patient relationship and the inherent undesirability of moving patients.

Previous articles in HEALTH elaborate on the reduced Medical Corps officer requirements and the improved geographic distribution of beds that were expected to result from the closure of the first group of hospitals by 31 December. Operational data just now available indicate that the third objective has received due weight. When the hospitals slated for closure by 31 December were blocked for the receipt of patients on 10 October, they had 37,000 patients, with 27,000 physically present. They have been separating patients rapidly, and by their respective dates of closure -- which frequently antedate 31 December by as much as a month -- the aggregate number of long-time patients requiring transfer to other general hospitals for continuation of treatment will approximate 5,000, with general and orthopedic surgery patients constituting about three quarters of the total.

Staggering of closure dates was necessary because of limited hospital train facilities and personnel available to move patients. The general pre-dating of closures was accom-

ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



* Adjusted to four-week months. ** Total admissions less dispositions by transfer.

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

plished by consolidating the short-time patients of contiguous blocked general hospitals in which patient censuses were falling off, in order to maximize savings in hospital operating personnel. Similar consolidation of short-time patients of hospitals at some distance from each other would probably not be so advantageous.

Rapid reduction in the patient load of the convalescent hospitals has permitted drastic revision of their authorized capacities and closure of Butner Convalescent Hospital earlier than anticipated.

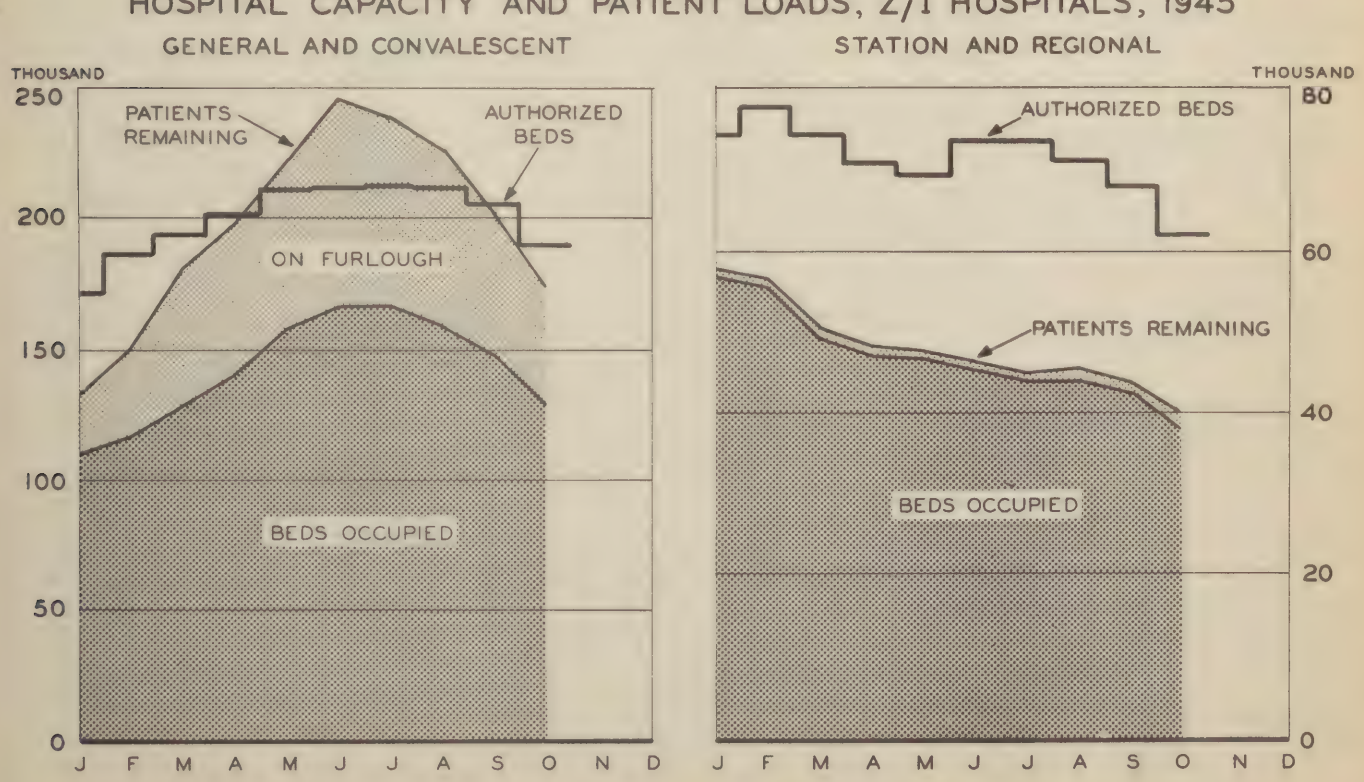
Authorized capacities of the general and convalescent hospitals as of the end of October reflect the beginning of the closure program. Stark General Hospital was closed on 15 October and Camp Pickett Convalescent Hospital on 27 October. In addition occasional minor reductions in authorized bed capacities were accomplished, preliminary to closure or to permit accommodation of the detachments in their former barracks.

The authorized capacity of 156,000 that remains as of the end of October is distributed between beds in active and in closing hospitals. The blocking on 10 October of the 19 additional general hospitals scheduled for closure before the end of 1945 removed 36,000 beds from the number available to the Medical Regulating Officer. This has made for substantial tightness in operation.

Beds authorized in station and regional hospitals declined from 67,800 at the end of September to 61,700 at the end of October. Total patients remaining declined by 3,800 during the month. The principal portion of the drop occurred in the patient load of the regional hospitals, which are generally located on large posts. Troop concentrations on these posts are shrinking in size as a result of demobilization. The separation of Medical Corps specialists, and the resultant scarcity, require maximum care in their utilization, thereby necessitating a review of the existing pattern of regional hospitalization. Undoubtedly an increasing proportion of regional hospitalization will have to be performed in the remaining general hospitals.

In line with the demobilization of the Army, total personnel assigned to ASF hospitals in the zone of interior declined somewhat. Although the number of Medical Corps officers assigned declined by less than 200, a much more significant decline was experienced in the number of highly qualified specialist personnel. In the course of the month, approxi-

HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITALS, 1945



HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

mately 1,000 newly commissioned officers were assigned to the service commands from Carlisle during the same period, more than 1,000 experienced officers, a large number of them specialists, were separated. It is contemplated that upon the completion of the present closure operations which are taking place for the most part in the Fourth, Eighth and Ninth Service Commands, it may be possible to ease the specialist situation in the other service commands by a reallocation of personnel.

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR
End of October 1945

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages c/		
	Authorized	Effective a/	Number b/	Percent of Effective Beds		MC	ANC	Total
Total	251,620	230,121	214,104	93.0	165,366	-246	-478	1,720
General	156,721	149,401	153,007	102.4	111,377	- 43	-191	4,016
Convalescent	33,200	33,200	21,361	64.3	16,252	86	- 16	445
Regional	28,807	23,046	21,455	93.1	19,833	-156	-164	- 660
Station d/	32,892	24,474	18,281	74.7	17,904	-133	-107	-2,081

a/ Less debarkation beds and 20 percent for dispersion in regional and station hospitals.
b/ Data exclude patients in triage at debarkation hospitals.
c/ Civilian nurses included. Overages are denoted with a minus sign (-) in all columns.
d/ Includes hospitals under the Chief of Transportation.

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS
BY TYPE OF CARE AND TYPE OF HOSPITAL a/
End of October 1945

Type of Patient	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station b/
Total	242,000	214,104	153,007	21,361	21,455	18,281
General-Convalescent Care	156,690	144,867	123,751	21,116	-	-
Evacuees		130,458	110,091	20,367	-	-
Z/I		14,409	13,660	759	-	-
Regional-Station Care	71,617	55,606	20,049	210	20,121	15,226
Regional	11,266	10,691	4,608	-	6,083	-
Station	60,351	44,915	15,441	210	14,038	15,226
Non-Army	13,693	13,631	9,207	35	1,334	3,055
POW	8,488	9,653	6,727	23	703	2,200
Civilians	2,991	2,646	1,366	12	513	755
Veterans Administration	1,775	822	726	-	79	17
Other	439	510	388	-	39	83

a/ Excludes debarkation beds and patients.
b/ Includes hospitals under the Chief of Transportation.

Summary.

1. Liquidation of the general and convalescent hospital system has actively begun. Actual operations antedate plans wherever possible.

2. Specialist personnel qualified to care for the residue of long-term patients is becoming scarce.

3. Maximum economies in utilization of specialist personnel are necessary. The following steps may be appropriate:

a. Reduction in the number of regional hospitals.
b. Reallocation of existing specialist personnel among service commands.
c. Blocking of separations for selected categories of specialists wherever necessary.

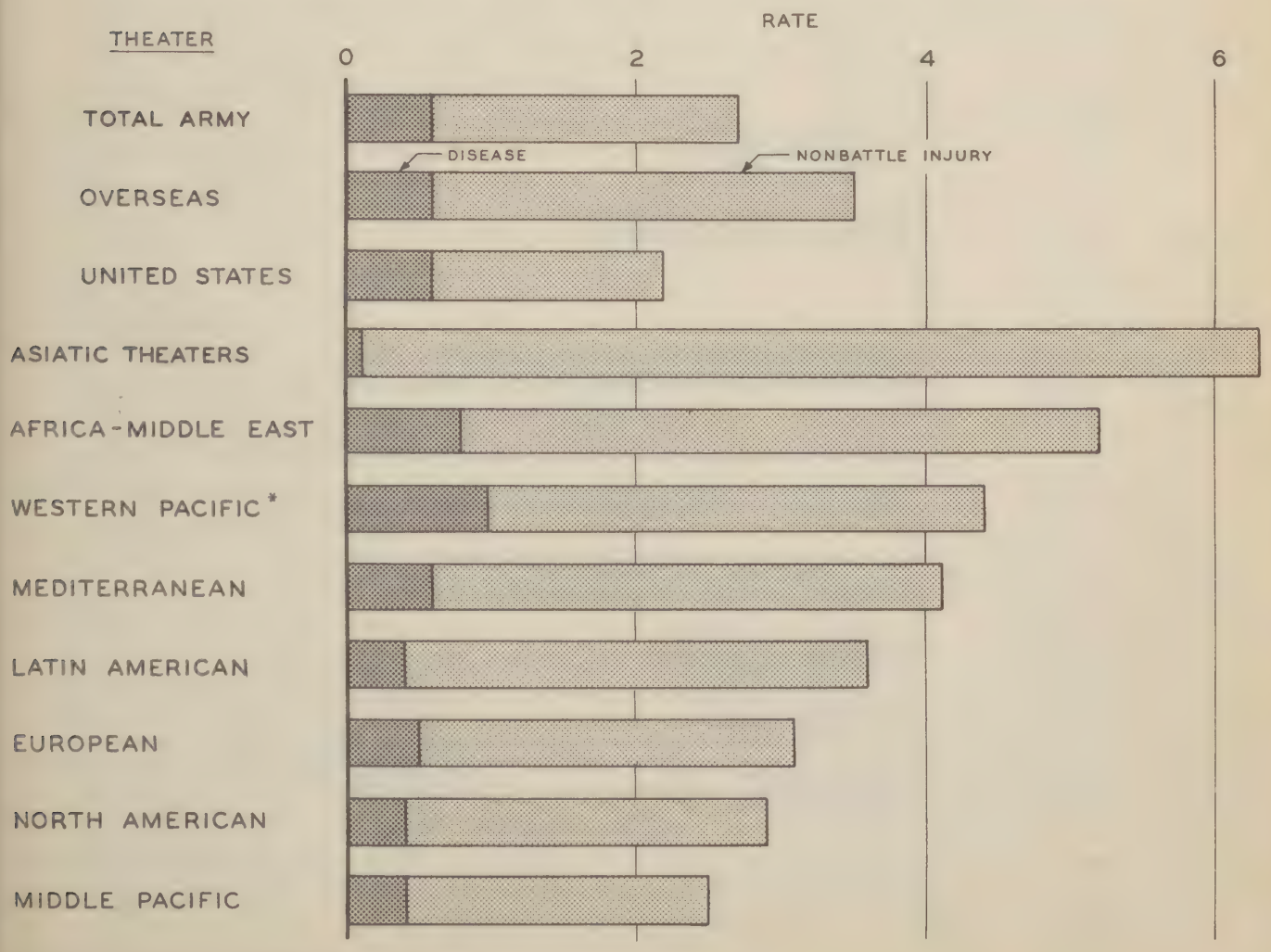
MORTALITY DURING WORLD WAR II

During the 44 months of the war from January 1942 through August 1945 there were about 266,500 deaths among Army personnel. Of these, 164,000 or 62 percent were killed in action, 26,300 or ten percent died of wounds, 13,800 or five percent died of disease, 50,100 or 19 percent died of accidental injuries, and 12,300 or less than five percent have been declared dead or determined to be dead after having been reported as missing in action. These counts are reasonably complete with the possible exception of the last one which will increase to the extent that persons still missing on 1 September 1945 are either found to be or are declared dead. The average death rate for all causes during the war was 11.3 per thousand men per year. Except as noted there the table on page 19 compares World War II with other major wars in which the United States has engaged. The rates for the Army overseas and for the total Army in World War II exclude the 4,700 battle deaths which occurred in the Philippines from January through May 1942. Also excluded are an additional 450 battle deaths which occurred in Hawaii and the Philippines during December 1941. The best available estimate of all battle deaths in World War II, therefore, is not 190,000 but 195,000 deaths excluding those declared or determined to be dead, or 8.4 deaths per thousand men per year.

When the various wars are compared the most notable differences are in the rates for deaths from disease. These declined from 104 per thousand men per year in the Mexican War and 71 in the Civil War to 0.6 for World War II. The World War II rate for accidental deaths is well above the figure of 1.4 for World War I entirely because of aircraft accidents, about 43 percent of all nonbattle injury deaths during World War II being attributable to this cause. If these deaths are excluded the World War II death rate for accidental injuries is only 1.2. The charts below and at the bottom of the following page compare the battle and nonbattle death rates for troops in the various overseas theaters, for the total Army, and

NONBATTLE DEATHS DURING WORLD WAR II

DEATHS PER THOUSAND MEN PER YEAR, JANUARY 1942 - AUGUST 1945



*Excluding Philippine Islands for Jan-May 1942

MORTALITY DURING WORLD WAR II (Continued)

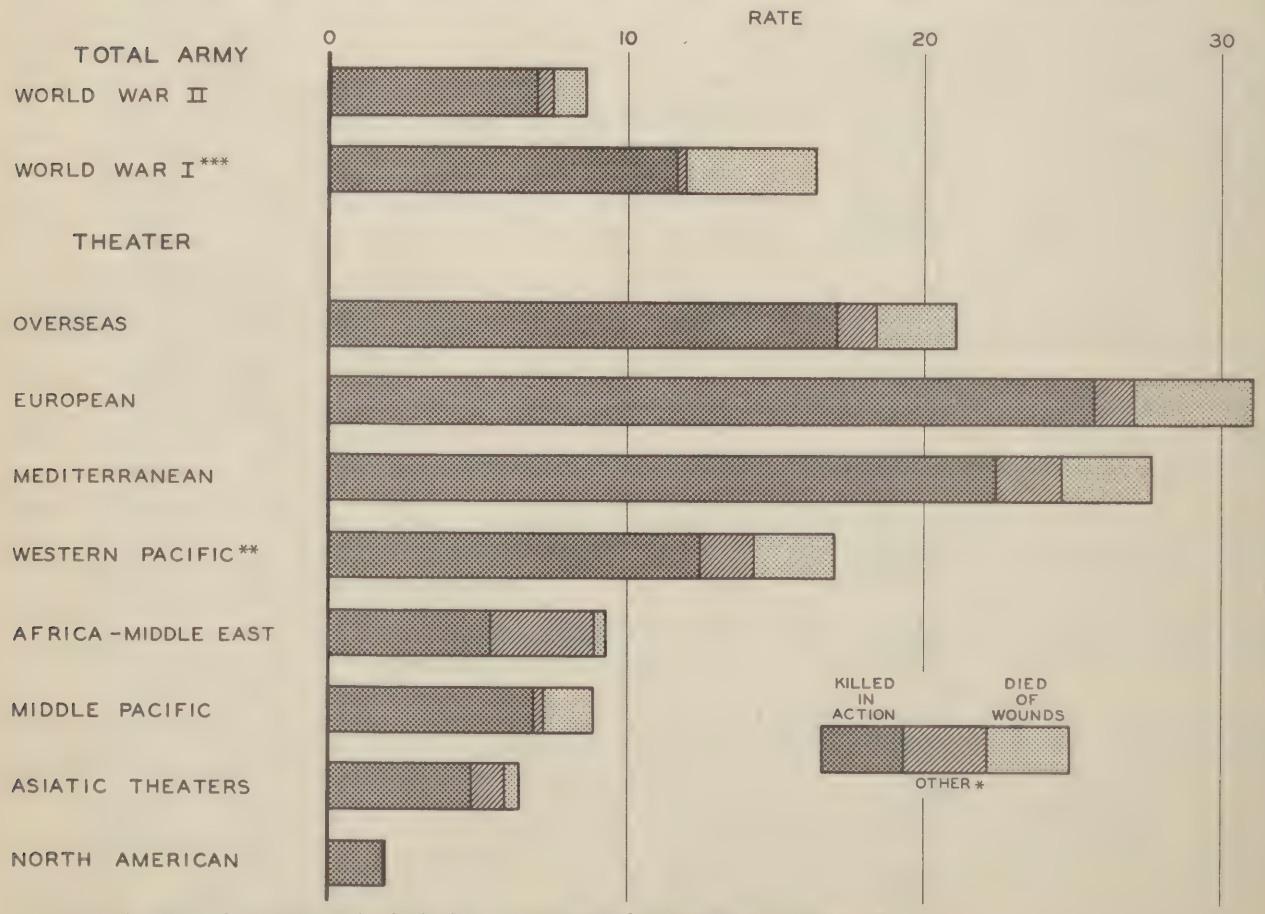
for Army strength in the Z/I during World War II. Much of the variation in battle death rates between the various wars may be attributed to different proportions of service personnel. Not only does the modern field army contain a smaller proportion of combat personnel then previously, but the numerical significance of base area and Z/I personnel is also much greater.

During the recent war period (Jan 1942 - Aug 1945) about 14,900,000 disease patients and 2,000,000 nonbattle injury patients were admitted to hospital or quarters. Based upon this aggregate experience 0.09 percent of the disease and 2.5 percent of the nonbattle patients died. Thus the chance of dying after admission was about one in 1,080 for disease patients and one in 40 for the injured. These fatality rates for nonbattle causes are not directly comparable with those for the battle causes because for the latter only hospital admissions are tabulated in such a way that these percentages may be obtained. For hospital admissions for wounded, numbering almost 600,000 men, 26,300 or 4.4 percent died of wounds. The chance of dying after being admitted to hospital was, therefore, about one in 23. The fatality from battle causes, including men killed in action, was 25 percent, one out of every four men hit either being killed in action or dying of wounds after admission to a hospital. In comparison, the fatality among wounded men in World War I was 8.1 percent for all wounded and 6.1 percent for the wounded plus the gassed for whom the comparable percentage is 1.7.

The following table compares the different wars and the various theaters in this war from the standpoint of the proportions of those hit who died, and the proportions of wounded who died of wounds. During World War II the high proportion of deaths among wounded in the Pacific Theaters was maintained throughout the war period and is in substantial agreement with information contained in medical reports. The high proportions of men hit who were killed in the Asiatic and Africa-Middle East Theaters may be attributable to the special characteristics of air war. The numbers also are small.

BATTLE DEATHS DURING WORLD WAR II

DEATHS PER THOUSAND MEN PER YEAR, JANUARY 1942 - AUGUST 1945



* Declared dead or determined to be dead after being reported as missing in action.
** Excluding Philippine Islands, Jan - May 1942.
*** Including gassed.

MORTALITY DURING WORLD WAR II (Continued)

ARMY DEATHS IN VARIOUS WARS
Deaths Per Thousand Men Per Year

War	Total Deaths		Battle Deaths			Nonbattle Deaths		
	Number	Rate	Total a/	Killed	Died	Total	Disease	Injury
WORLD WAR II b/								
Total Army	266,500	11.3	8.6	7.0	1.1	2.7	0.6	2.1
Overseas	235,600	24.6	21.1	17.1	2.7	3.5	0.6	2.9
United States	30,900	2.2	-	-	-	2.2	0.6	1.6
WORLD WAR I	107,127	34.3	16.4	11.7	4.4	17.9	16.5	1.4
SPANISH WAR	5,462	38.7	2.7	1.9a/	0.8	36.0	34.0	2.0
CIVIL WAR (NORTH)	359,528	101.5	34.9	21.3a/	13.6	74.6	71.2	3.4
MEXICAN WAR	12,934	122.3	14.7	9.9a/	4.8	107.6	103.9	3.7

a/ Includes men determined dead and declared dead after being reported as missing, and based on reports to The Adjutant General.
b/ Includes deaths from January 1942 through August 1945 except for Philippines from January through May 1942.

PROPORTION OF MEN HIT WHO WERE KILLED OR DIED OF WOUNDS,
AND FATALITY AMONG WOUNDED MEN IN VARIOUS WARS

War and Theater	Percent of Men Hit a/ Who			Hits Per Battle Death	Wounded Admitted to Hospital	
	Were Killed	Died of Wounds	Were Killed or Died		Wounded per Death from Wounds	Percent Who Died
WORLD WAR II b/						
Total Army	21.6	3.5	25.1	4.0	22.7	4.4
North American	45.4	0.8	46.2	2.2	72.5	1.4
European	20.8	3.3	24.1	4.1	24.2	4.1
Mediterranean	22.8	3.0	25.8	3.9	25.8	3.9
Pacific Ocean Areas c/	18.8	4.6	23.4	4.3	17.5	5.7
Southwest Pacific d/	22.8	4.9	27.7	3.6	15.8	6.3
Asiatic Theaters c/	40.3	4.0	44.3	2.3	15.1	6.6
Africa-Middle East	54.5	3.8	58.3	1.7	12.1	8.3
WORLD WAR I - Total Army						
Gassed	f/	f/	f/	f/	57.8	1.7
Wounded	f/	f/	f/	f/	12.3	8.1
Total	14.1	5.2	19.3	5.2	16.4	6.1
SPANISH WAR e/	14.5	5.7	20.2	4.9	15.0	6.7
CIVIL WAR (NORTH) e/	18.0	11.5	29.5	3.4	7.1	14.1
MEXICAN WAR e/	23.5	11.4	34.9	2.9	6.7	14.9

a/ Killed plus died of wounds plus living wounded. For World War II, wounded are hospital admissions only and are from reports to The Adjutant General.
b/ January 1942 through August 1945.
c/ Includes casualties of that part of 20th Air Force which operated from this theater.
d/ Excludes Philippine Islands from January 1942 through May 1942.
e/ Counts of killed in action include deaths among prisoners of war.
f/ Data not available.

STATISTICAL TABLES

Admission rates for selected diseases and for nonbattle injury in the United States and in overseas theaters are shown in the tables on the following pages. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from AGO Form 8-122 (formerly MD Form 86ab), both regular and telegraphic, submitted to The Surgeon General by each overseas theater or lesser command, and by posts, camps, and stations in the United States. Only the major overseas areas are shown separately, but the total overseas rates are based upon complete consolidations. The rates for each month average the experience of either four or five weeks depending upon the number of Fridays in the month. In each case they apply to all Army strength in the particular area: air, ground, and service. Rates computed from incomplete reports and those derived from the weekly telegraphic reports are distinguished from those based on final monthly reports. Admission rates for wounded in action, previously published on this page, are no longer shown. In their place appear separations of enlisted men for mental and physical disqualification under AR 615-368, covering undesirable habits and traits of character, and AR 615-369, covering inaptness, lack of required degree of adaptability, and enuresis. The series pertains to month of separation and is derived from reports of The Adjutant General through May 1945, and thereafter upon preliminary reports submitted to The Surgeon General weekly on AGO Form 8-122. The latter have been adjusted to calender months to conform with those reported by The Adjutant General.

The series shown for nonbattle injury is not entirely comparable throughout. In September 1944 a change in reporting provided that all readmissions for nonbattle injury be classified as disease admissions. The venereal disease rates derived from AGO Form 8-122 are generally higher than those based on the Monthly Venereal Disease Statistical Report. Venereal infections contracted prior to service have been excluded from the rates. Tentative neuropsychiatric admission rates are presented for 1944 and 1945. Not systematically reported on AGO Form 8-122 until late in 1943, these rates may not be as firm as those for communicable diseases. Malaria rates for the continental United States reflect only infections acquired in the United States; rates based on all admissions are much higher. They also measure diagnosed malaria only, but include both primary attacks and recurrences insofar as these are reported as malaria. A variable amount of malaria, differing from theater to theater, is at first reported as fever of undetermined origin. Many of these cases are later correctly diagnosed and enter into the rates. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, some duplication between malaria and fever of undetermined origin continues to exist.

DISCHARGES OF ENLISTED MEN FOR DISABILITY
Number of Men Discharged and Rates Per Thousand Enlisted Men Per Year

Year and Month	Number of Men Discharged			Discharges Per 1000 Enlisted Men Per Year		
	All Causes	Wounded a/	Neuropsychiatric a/	All Causes	Wounded a/	Neuropsychiatric a/
1942	62,013	30	26,091	20.8	0.0	8.8
1943	348,964	b/	138,609	56.2	b/	22.3
1944	205,091	b/	97,860	29.0	b/	13.8
1945 Jan	15,143	1,346	6,751	22.1	2.0	9.9
Feb	15,356	1,311	7,369	24.7	2.1	11.9
Mar	19,873	1,663	10,028	28.7	2.4	14.5
Apr	18,278	1,916	8,441	27.1	2.8	12.5
May	24,457	3,911	10,624	34.8	5.6	15.1
Jun c/	30,510	5,270	12,460	44.8	7.7	18.3
Jul c/	37,740	7,570	13,280	54.0	10.8	19.0
Aug c/	41,390	9,550	12,620	60.1	13.9	18.3
Sep c/	44,750	12,160	13,160	69.7 d/	18.9 d/	20.5 d/
Oct c/	51,440	14,330	12,540	85.5 d/	23.8 d/	20.8 d/
Nov						
Dec						
Total Through 31 October	915,005	b/	369,833			
Percent of Total	100.0	b/	40.4			

a/ Discharge Diagnosis
b/ Not Available
c/ Estimated from AGO Form 8-122 and Adjusted to Calendar Months.
d/ Based upon Preliminary Strengths.

STATISTICAL TABLES (Continued)

WAR PERIOD SUMMARY OF ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year, January 1942-August 1945

Command	All Causes	Disease	Nonbattle Injury	Wounded e/	Total Respiratory
Total Army	779	661	89	29	185
United States	719	645	74	-	213
Overseas Total	871	685	113	73	143
North American a/	695	552	140	3	206
Latin American	762	671	91	0	107
European	754	542	101	111	154
Mediterranean	1,065	842	130	93	158
Pacific Ocean Areas	738	594	106	38	88
Southwest Pacific b/	1,111	929	134	48	117
Asiatic Theaters	1,022	918	93	11	168
Africa-Middle East c/	1,041	926	110	5	199

Command	Diagnosed Malaria	Diarrhea & Dysentery	Total Venereal d/	Dengue	Infectious Hepatitis
Total Army	20	22	39 f/	g/	g/
United States	6 h/	9	32 f/	g/	g/
Overseas Total	41	42	50	9	14
North American a/	0	5	8	0	8
Latin American	45	20	53	1	3
European	7	14	58	-	7
Mediterranean	50	71	92	0	27
Pacific Ocean Areas	73	31	6	25	8
Southwest Pacific b/	80	75	33	35	30
Asiatic Theaters	115	143	49	19	9
Africa-Middle East c/	76	132	68	0	6

a/ Includes Alaskan Department and Iceland.
b/ Excludes Philippine Islands from January through May 1942.
c/ Includes Persian Gulf Command.
d/ Excludes cases contracted prior to induction.
e/ Hospital and quarters admissions for wounded are about 18 percent greater than hospital admissions only for all theaters. They were about 13 percent greater for ETO, and about 22 percent greater for MTO.
f/ Including EPTS cases for the Z/I this rate would advance to 47 for the Z/I and 48 for the Army as a whole.
g/ Not available.
h/ Includes malaria acquired overseas. Rate for malaria acquired in the United States is 0.2.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
ALL DISEASE										
1942 Average	664	676	667	823	693	452	519	821	1,048	1,330
1943 Average	739	889	624	670	837	943	971	1,046	991	1,107
1944 Jan-Jun	619	695	566	528	578	812	600	902	967	949
Jul-Dec	495	623	351	536	440	880	513	804	1,152	842
Average	563	654	478	531	492	846	561	840	1,077	896
1945 Jan	603	656	337	529	605	878	420	799	728	658
Feb	626	649	363	587	577	790	526	905	652	554
Mar	592	612	384	546	530	714	412	973	647	631 b/
Apr	543	587	411	553	469	657	414	1,058	710	573
May	541	633	658	515	531	600	436	1,144	712	582
Jun	515	651	435	629	532	704	475	1,128	788	532
Jan-Jun	569	631	426	562	538	726	448	1,006	707	587
Jul	471	650	381	572	528	654	542	1,038	875	577
Aug	478	621	346	531	501	645	466	891	796	620
Sep	442	(589)		465	456	649	465			539
Oct	445 b/									
Nov										
Dec										
NONBATTLE INJURY										
1942 Average	91	123	152	107	109	96	104	176	80	158
1943 Average	80	136	182	105	100	149	131	171	84	140
1944 Jan-Jun	69	114	145	75	85	145	118	151	95	107
Jul-Dec	66	112	100	61	105	131	102	132	97	92
Average	67	113	127	68	97	138	111	139	96	99
1945 Jan	55	141	102	60	174	103	92	104	105	69
Feb	50	105	94	67	114	88	84	103	99	73
Mar	49	102	109	61	104	89	71	128	105	69 b/
Apr	48	108	100	65	113	98	92	115	104	64
May	49	108	84	57	112	97	105	119	91	59
Jun	53	91	92	59	87	85	98	113	83	62
Jan-Jun	51	108	97	61	115	93	90	114	98	66
Jul	48	80	89	54	71	72	95	104	80	53
Aug	44	73	90	50	56	62	85	107	68	71
Sep	36	(71)		40	50	55	72			35
Oct	31 b/									
Nov										
Dec										

a/ Excluding Iceland.
b/ Based on Incomplete Reports.
( ) Telegraphic Reports.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
ALL VENEREAL DISEASE										
1942 Average	29	32	7	74	38	36	12	32	64	80
1943 Average	26	34	3	56	43	56	5	15	52	68
1944 Jan-Jun	30	37	3	33	26	96	6	9	53	60
Jul-Dec	37	45	7	33	40	125	4	6	50	62
Average	33	42	5	33	35	111	5	7	51	60
1945 Jan	47	46	6	29	48	124	4	5	54	80
Feb	43	42	8	29	45	105	3	8	57	75
Mar	43	47	10	26	48	94	3	40	51	74 b/
Apr	43	51	8	27	46	85	3	84	43	84
May	43	63	8	25	62	94	3	97	40	63
Jun	44	88	12	20	105	110	5	97	38	69
Jan-Jun	44	57	9	26	60	102	3	57	47	74
Jul	46	105	7	21	136	128	5	94	42	79
Aug	53	111	8	17	155	142	4	77	40	73
Sep	57			18	154	213	4			77
Oct	57 b/									
Nov										
Dec										
DIAGNOSED MALARIA										
1942 Average	0.6	33	0	99	0	11	12	52	165	127
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Jan-Jun	0.1	43	-	16	10	61	67	75	113	66
Jul-Dec	0.2	34	-	12	8	63	13	41	216	52
Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan	0.1	14	0	7	5	19	8	27	74	11
Feb	0.2	14	-	7	5	16	6	43	49	9
Mar	0.1	18	-	7	8	21	4	62	28	10 b/
Apr	0.2	23	-	9	11	28	5	75	29	11
May	0.1	23	0	11	11	31	6	72	23	9
Jun	0.1	20	0	12	9	26	4	65	28	14
Jan-Jun	0.1	19	0	9	8	23	5	58	37	11
Jul	0.1	16	1	12	6	24	4	46	33	14
Aug	0.1	12	-	8	3	15	2	29	31	13
Sep	0.1			9	1	8	3			12
Oct	0.1 b/									
Nov										
Dec										

a/ Excluding Iceland.
b/ Based on incomplete reports.
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
COMMON RESPIRATORY AND INFLUENZA										
1942 Average	243	159	244	113	287	151	89	146	150	197
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Jan-Jun	198	174	245	84	225	185	97	90	177	254
Jul-Dec	85	100	105	77	92	138	70	78	176	182
Average	147	132	188	81	142	162	85	83	176	219
1945 Jan	167	146	106	67	166	190	70	95	135	180
Feb	192	144	135	71	157	182	60	128	135	149
Mar	167	122	115	65	125	152	54	125	131	164 b/
Apr	122	99	143	74	93	106	56	131	130	127
May	124	97	417	75	87	79	55	139	136	92
Jun	101	89	182	193	63	70	90	145	163	88
Jan-Jun	145	115	177	95	112	132	65	128	139	132
Jul	77	93	90	150	56	61	99	180	182	108
Aug	79	96	85	105	66	69	91	151	157	115
Sep	72			117	63	66	60			116
Oct	80 b/									
Nov										
Dec										
DIARRHEA AND DYSENTERY										
1942 Average	8	28	5	19	17	33	34	57	120	185
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Jan-Jun	9	35	3	13	11	41	28	58	182	101
Jul-Dec	10	40	3	12	14	67	28	54	180	129
Average	9	38	3	13	13	54	28	55	181	115
1945 Jan	8	30	1	11	17	20	17	76	69	56
Feb	8	36	2	14	20	21	27	99	68	31
Mar	6	34	2	21	13	19	14	119	83	45 b/
Apr	6	33	3	14	15	18	18	90	116	81
May	6	34	2	14	16	22	21	88	118	135
Jun	7	44	0	16	14	31	30	138	128	90
Jan-Jun	7	35	2	15	16	22	22	104	98	73
Jul	6	45	1	15	20	30	24	106	151	120
Aug	8	38	1	11	17	25	12	75	122	106
Sep	7			10	9	15	13			87
Oct	4 b/									
Nov										
Dec										

a/ Excluding Iceland.
b/ Based on Incomplete Reports.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
FEVER OF UNDETERMINED ORIGIN										
1943 Average	c/	52	0	64	1	75	19	166	71	21
1944 Jan-Jun	c/	35	1	37	1	57	26	102	69	16
Jul-Dec	c/	40	0	31	3	85	13	80	174	37
Average	c/	38	1	34	2	71	20	88	131	27
1945 Jan	c/	24	0	20	4	39	5	70	87	12
Feb	c/	26	-	10	4	43	9	95	60	24
Mar	c/	29	0	10	6	41	3	117	56	31 b/
Apr	c/	29	-	9	8	43	8	104	59	33
May	c/	31	0	10	9	38	10	113	70	35
Jun	c/	29	0	10	6	50	8	98	89	29
Jan-Jun	c/	28	0	12	6	42	7	100	70	28
Jul	c/	30	1	7	5	57	10	86	102	50
Aug	c/	22	0	6	5	58	5	38	91	59
Sep	c/			8	3	41	3			49
Oct										
Nov										
Dec										
NEUROLOGICAL AND PSYCHIATRIC DISORDERS										
1944 Jan-Jun	29	29	11	21	24	37	26	48	23	27
Jul	32	59	10	16	84	52	27	58	16	31
Aug	36	50	12	18	76	28	25	48	17	21
Sep	46	41	13	25	40	50	32	53	16	19
Oct	48	56	13	23	65	82	32	39	21	21
Nov	47	60	13	27	85	47	28	41	23	16
Dec	47	56	12	22	72	39	29	53	20	26
Jul-Dec	45	53	12	22	69	50	29	49	19	22
Average	36	43	12	21	52	43	27	48	20	25
1945 Jan	50	43	14	25	51	32	35	43	19	20
Feb	49	39	9	27	36	31	25	70	20	15
Mar	50	40	13	29	39	31	25	74	22	20 b/
Apr	45	36	13	26	31	41	34	60	24	11
May	49	24	9	20	15	13	19	67	22	8
June	43	20	14	20	13	13	20	49	26	13
Jan-Jun	48	33	12	24	30	27	26	60	22	15
Jul	39	18	11	23	10	12	25	38	25	10
Aug	37	17	16	18	8	14	21	35	22	12
Sep	26			15	7	12	30			7
Oct										
Nov										
Dec										

a/ Excluding Iceland. b/ Based on incomplete reports. c/ Not available.
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.